Periscope.

EXCERPTS WILL BE FURNISHED AS FOLLOWS:

From the Swedish, Danish, Norwegian and Finnish:
FREDERICK PETERSON, M.D., New York.

From the German:
WILLIAM M. LESZYNSKY, M.D., New York.
BELLE MACDONALD, M.D., New York.

From the French:
L. FISKE BRYSON, M.D., New York.
G. M. HAMMOND, M.D., New York.

From the French, German and Italian:
JOHN WINTERS BRANNAN, M.D., New York.

From the Italian and Spanish:
WILLIAM C. KRAUSS, M.D., Buffalo, N. Y.

From the Italian and French:
E. P. HURD, M.D., Newburyport, Mass.

From the German, Italian, French and Russian:
F. H. PRITCHARD, M.D.
ALBERT PICK, M.D., Paris, France.

From the English and American:
A. FREEMAN, M.D., New York.

From the French and German:
W. F. ROBINSON, M.D., Albany.

PATHOLOGICAL.

THE THEORY OF MOTOR DISTURBANCES IN TABES.

In the Wiener klin. Wochenschrift, 1890, No. 19, Mader formulates his views in the following propositions:

1. The tabetic ataxia does not depend upon a disturbance either of the motor centres or the motor tracts. It is therefore incorrect to speak of a disturbance of coördination.

2. The tabetic ataxia is due exclusively to an obstruction in the sensory reflex paths, viz.:

a. The spinal tendon reflexes (exaggerated movements, swinging and stamping gait, uncertainty in grasping, etc.

b. The conscious sensations of equilibrium, ascending in the posterior columns to the cerebellum (symptoms of vertigo, staggering and reeling gait, Romberg's phenomenon).

c. Only the manifestations described under *a* are characteristic of tabes.

Other apparent disturbances of motility in tabes, such as the reflex pupillary rigidity; the paresis affecting the bladder, the rectum or the sexual organs, and vaso-motor disturbances seem also to be due to a lesion of sensory reflex paths.

The joint affections in tabes seem mostly to be the result of analgesia in the superficial portion of the joints, so that the twisting and jerks consequent upon the peculiar gait produce an inflammation which is unnoticed by the patient, owing to the loss of sensation.

Indeed genuine motor paralyses also occur in tabes, such as ocular paralyses. On the other hand, paralyses of the lower extremities seem only to arise through an extension of the process to the pyramidal tracts. Finally, the writer takes exception to Jendrassik's view that the causes of the tabetic disturbances of sensibility exist in the cerebral cortex, but believes that the same may be readily accounted for by changes in the sensory paths in the posterior roots, and their spinal prolongations. (Centralbl. f. klin. Med., No. 4, 1891.) W. M. L.

COMPRESSION MYELITIS OCCURRING IN VERTEBRAL CARIES.

In a recent work upon this subject (H. Schmaus, Wiesbaden, J. F. Bergmann, 1890) the author reaches the following conclusions:

1. Apart from the direct bruising of the cord through displacement of the vertebræ, etc., the degeneration of the cord arising in vertebral caries is due to œdema, which, when of long standing, develops into a diffused softening.
2. A true myelitis occurs only in rare cases, through extension inward of the inflammatory process existing in the vertebral column. There arises almost always a pachymeningitis, and often a meningitis.
3. Myelitis may be assumed only when the process existing in the spinal cord shows all of the characteristics of a preceding external inflammation. In tubercular vertebral caries, only when true tuberculosis occurs in the spinal cord.
4. All other incidental processes are due to inflammatory reaction, arising as a result of the softening, which may terminate in sclerosis.
5. The œdema arising in the cord is, in many instances, due to venous obstruction. In others it is an inflammatory œdema. But it is most frequently due to their combination.
6. The collateral œdema is to be ascribed to the effect of ptomaines; an analogous condition may be produced by chemical processes.
7. Anæmic and embolic softening plays no important part in compression myelitis.